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Supreme Court, U.S.
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NO.

# In The
# Supreme Court Of The United States

OCTOBER TERM, 1985

GUILLERMO ALEMAÑY,
*Petitioner,*

v.

UNITED STATES OF AMERICA,
*Respondent.*

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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## QUESTION PRESENTED

May the Court of Appeals for the First Circuit open a veritable Pandora's box by allowing criminal fraud prosecutions against medicare providers whenever an intermediary under the Medicare Act determines that a provider has sought reimbursement for supplies or services provided by a related organization to the one with whom the provider is associated?

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Petitioner, Guillermo Allemañy, respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the First Circuit entered on December 26, 1985.

## OPINION BELOW

The judgment of the Court of Appeals for the First Circuit, not reported, is reprinted on Appendix A hereto. It affirms a conviction of the United States District Court for the District of Puerto Rico, after a trial by jury.

## JURISDICTION

The judgment of the United States Court of Appeals for the First Circuit issued on December 26, 1985. The jurisdiction of the Court to review the judgment on petition for certiorari rests upon 18 U.S.C. 3772 and Rule 20 of the Rules of this Court.

## STATUTES INVOLVED

The relevant statutes involved are §§ 1001 and 2 of Title 18, United States Code and §§ 1385, et seq., of Title 42, United States Code.

## STATEMENT OF THE CASE

This case commenced with the filing of an indictment against herein petitioner Guillermo A. Alemañy and Dr. Edgar Stella; controller and president of the board of directors, respectively, of the Hospital Nuestra Señora de Guadelupe, a private hospital located in San Juan, Puerto Rico. Both defendants were accused of conspiracy, making false oaths in a bankruptcy proceeding and concealing material facts in documents within the jurisdiction of an agency of the United States, in this case, the Department of Housing and Urban Development (HUD) and the Health and Human Services (DHHS), in connection with a federally insured $12.46 million mortgage loan obtained by the Hospital for remodelling and expansion, violating thereby 18 U.S.C. 1001 and 2.

Count one alleged that Stella and an unindicted co-conspirator named José A. Cardona Alvarez, the Hospital's former assistant administrator, controlled a furniture company known as Casa Cardona, Inc., and its subsidiary, an equipment company by the name of AAA Hospital Supply, Inc. Stella and Cardona allegedly used these two corporations, with herein petitioner's assistance, to siphon off the Hospital's mortgage funds by selling equipment and furnishings to the Hospital at inflated prices, and by charging the Hospital for equipment that the corporations never furnished. Counts two through four of the indictment charged Dr. Stella and herein petitioner with submitting and causing to be submitted false documents to HUD to procure mortgage funds. Counts five through seven charged the defendants with submitting and causing to be submitted false Medicare cost reports for the years 1977, 1978 and 1979. Counts eight and nine charged Dr. Stella and petitioner with making, aiding, and abetting false oaths in bankruptcy with personal bankruptcy petitions filed by Stella and his wife in 1979.

After a jury trial, Dr. Stella was found guilty in all counts and herein petitioner was only convicted of conspiracy and counts 5 and 6 of the indictment. Herein petitioner was sentenced to imprisonment for a period of five (5) years on the conspiracy charge and five (5) years on count five, said periods of imprisonment to be served consecutively with each other, together with a $5,000.00 fine in each count. On count six, petitioner was sentenced to a prison term of five (5) years, to be served concurrently with sentence imposed on count five, but consecutively with the sentence imposed on count one. In sum, herein petitioner was sentenced to 10 years in prison and $10,000.00 in fines, having to remain committed until the fines are paid or otherwise discharged by due course of law.

An appeal was filed before the United States Court for the First Circuit and herein petitioner was granted bail pending appeal. The Court of Appeals affirmed the judgment of the district court on December 26, 1985. Copy of the opinion of the Court of Appeals is included as Appendix A.

## REASONS FOR GRANTING THE WRIT

Petitioner submits that there is at least one major issue involved in this petition for certiorari. The same is as follows:

The false statement statute, 18 USC 1001, imposes criminal penalties on one who (1) makes a statement that (2) was false, (3) was material, (4) was made knowingly and willfully, and (5) was made in a matter "within the jurisdiction of any department or agency of the United States." See generally, White Collar Crime: False Statements, *18 Am. Crim. L. Rev.* 273 (1980). Herein petitioner contended before the district court that the statement upon which counts 5 and 6 were based, were not, at the moment the indictment was issued, within the jurisdiction of the Department of Health and Human Services (DHHS) and that these counts should be dismissed. See, *United States v. Rodgers*, _____ US _____, 80 L Ed 2d 492. The district court denied said request and

the Court of Appeals affirmed. Petitioner contends that the Court of Appeals erred in not determining that the principle of primary jurisdiction had been violated, creating thereby a state of uncertainty in the administration of the Medicare program and the opening of a Pandora's box which will result in numerous criminal fraud prosecutions against persons such as herein petitioner.

### A. Legal Framework

The Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. 1395, is a program that consists of two basic parts: Part A is primarily designed to provide basic protection for hospital and post hospital services to individuals who are aged 65 and over and is funded out of social security taxes. Part B is a voluntary supplementary medical insurance program primarily covering physicians' service and is funded partly by monthly premiums paid by the beneficiaries and by amounts contributed by the federal government. Hospital Nuestra Señora de la Guadalupe was a provider of hospital (Part A) services to Medicare beneficiaries under a contract with the Department of Health and Human Services when the charges against petitioner were brought.

Upon the Medicare Act, the federal government reimburses to providers of Medicare service the reasonable cost actually incurred in the efficient delivery of needed health (hospital) services. See, 42 U.S.C. 1395 c (V) (1) (a). Since the cost actually incurred in rendering such health services cannot be determined until the end of the provider's (hospital) fiscal year, an interim estimated payment is made throughout the year on a not less than monthly basis. See, 42 U.S.C. 1395 f. A final determination as to the cost actually incurred to be reimbursed to the provider (hospital) is made at the closing of the provider's fiscal year. Said determination is based on a "Cost Report" that has to be filed by the provider pursuant to the Medicare Regulations where all the allowable costs incurred by the provider in rendering health services

to all patients (Medicare and non Medicare) are stated. See, 20 C.F.R. 045, 405 (B).

After the total allowable costs are determined, said amount is divided by the total number of patient-days at the hospital to determine the allowable costs of one day stay at the Hospital (per diem). Such per diem is then multiplied by the total number of Medicare patient days at the hospital to determine the total Medicare reimbursable cost to the hospital by the federal government. If the interim payments made during the year exceed the determined total Medicare reimbursable cost to the hospital, there is an overpayment situation and the hospital has to return to the federal government any excess paid. To the contrary, if the interim payments result to be less than the reimbursable cost already paid, then there is an underpayment situation and the federal government must pay the hospital the unpaid balance.

Blue Cross of Florida was the "Intermediary" or agent of the Secretary of Health and Human Services which performed all the services, on behalf of the Secretary, as stated in 42 U.S.C. 1395 h, including among others, the interim and final payments to be made to the providers, and any necessary audits to the costs reports filed by said providers, in this case the Hospital Nuestra Señora de la Guadalupe, hereinafter the Hospital.

Upon receipt of a provider's cost report, the intermediary analyzes or undertakes any necessary desk or filed audit and makes the determination as to the amount of program reimbursement to the provider for the costs incurred in rendering services to Medicare beneficiaries. See, 20 C.F.R. 405, 1803. If the provider is dissatisfied with any "adjustment" made by the intermediary when auditing its cost report, it can request an intermediary hearing or a hearing before the Provider Reimbursement Review Board (PRRB) and thereafter judicial review of any such decision. See, 42 U.S.C. 1395oo (s); 20 C.F.R. 405, 1835. Within sixty days after a PRRB decision, the Secretary, on his or her own motion, may reverse,

affirm or modify that decision. 42 USC 1395 on (f) (i). Pursuant to the applicable provisions of the Administrative Procedure Act, 5 USC 701 et seq., the provider may then seek review of the agency's final decision in federal district court. 42 USC 1395oo (f) (i).

Among the "adjustments" that can be made by the intermediary to the cost report filed by the provider is the one under the "related organization" principle; Regulation § 405, 427, 20 C.F.R. 405, 427. Under said principle, the costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. The reasoning of said principle is that where a provider obtains items from an organization owned or controlled by the owner of the provider are in effect items obtained from itself. In such a situation Medicare reimburses the provider not the *charges* made by the related organization to the provider, where there is usually a mark-up benefit, but instead reimburses the provider the actual *cost* to the related organizations as if it were the provider itself.

In some cases where there is a related organization situation between the provider and the supplier of services, there might be instances where an exception can be made for not applying said requirement. See, 20 C.F.R. 405, 427 (d). In any event, the determination as to whether the related organization exists, or if the exception should be applied, is made by the intermediary but the provider has a right to administrative hearings and appeals and judicial review to contest the conclusion that the organization falls within the related organization guidelines.

**B. The Factual Setting Of The Present Case**

Hospital Nuestra Señora de la Guadelupe, the Hospital, filed its cost reports for the year ending 1977, 1978 and 1979. Blue Cross of Florida, the intermediary, analyzed the cost reports for years 1977 and 1978 and made a determination as to the amount of program reimbursement to the hospital. The hospital, being dissatisfied with the intermediary's determination, filed an administrative appeal to the Provider Reimbursement Review Board for said years. The administrative process on said appeals was deferred due to charges brought against herein petitioner, who was at that time the controller of the Hospital, and against Dr. Stella, its owner and medical director.

Petitioner requested the district court to dismiss counts five and seven since there had never been an administrative determination as to the existence of any such "related organization". The district court held that there was a distinction between the Hospital and the defendants in this case, and there was not identity between the defendants and Hospital Guadalupe. Therefore, the court held, there was jurisdiction to prosecute the defendants. The Court of Appeals affirmed. But under the Medicare Act, 42 C.F.R. 405, 1805, any party affected by a decision that is a related organization, can request an appeal to the Reimbursement Review Board. In this case, the government, through the Department of Justice, made a final determination that defendants, through two related companies, had made claims for payment which were not reimbursable. Either as a related party or as an interested person in the determination, appellant was entitled to a hearing and review of said determination. See, e.g. *Valley View Community Hospital v. United States,* 679 F 2d 847 (Ct. Cl., 1982).

The above is sustained by the fact that the government accused herein petitioner as the person who allegedly made the determination that there was no related organization situation. It is impossible to separate herein petitioner from the

Hospital so as to deprive him from a review of his decisions. A fortiori, this cannot be done when it is precisely in such capacity that petitioner allegedly made the decisions for which he was found guilty in this case.

It was not the government that had the burden of proving the related organization situation as an essential element of the offense. It was Congress that determined the administrative procedures for the review of a determination on the existence or not of a related organization situation. Cf. *United States v. Yermian*, 468 U.S. , 82 L Ed 53. It was not a question for the district court and certainly not for the jury. See, *Kechijian v. Califano*, 621 F 2d 2 (1st Cir. 1980).

There have been a host of situations wherein the provider has stated that there is not a related organization situation, and the intermediary, to the contrary, has contended, like the government here did, that a related organization existed. The ultimate decision was that the provider was correct.* No system could function if each time the provider contended there was no related organization and the intermediary disagreed, a criminal fraud prosecution would follow.** The

* See, *South Boston General Hospital v. Blue Cross of Virginia*, 409 F. Supp. 1380 (1976); *Northwest Community Hospital, Inc. v. Califano*, 442 F. Supp. 949 (1977); Blue Cross Association Provider Appeal Decision 79-2 CCH Medicare Medicaid Guide #29,940; Blue Cross Association Provider Appeal Decision 75-10 CCH Medicare Medicaid #27,375; Blue Cross Association Provider Medicaid Guide #27,401; Blue Cross Association Provider Appeal Decision 74-93, CCH Medicare Medicaid Guide #27,347; Blue Cross Association Provider Appeal Decision 74-89, CCH Medicare Medicaid Guide #27,515; Blue Cross Association Provider Appeal Decision 75-50, CCH Medicare Guide #28,120; Health Care Financing Administration Decision APR, 7178, CCH Medicare Medicaid Guide #29,030; Provider Reimbursement Review Board Decision 78 D10 Medicare Medicaid Guide #28,938, Provider Reimbursement Review Board Decision 78-D82, CCH Medicare Medicaid Guide #29,568; Blue Cross Association Provider Appeal Decision 00-27, CCH Medicare Medicaid Guide #26,917; Blue Cross Association Provider Appeal Decision 33-78-1 CCH Medicare Medicaid Guide #29,723.

** In the case of *Kechijian v. Califano*, 621 F 2d 1 (1980), the First Circuit held that the district court lacked jurisdiction to entertain a claim for reimbursement filed by a physician since under the Medicare Act this procedure had been confined to the Department of HEW and available administrative remedies had not been exhausted.

Court of Appeals ruling has opened a veritable Pandora's box which will result in criminal fraud prosecutions whenever an intermediary determines that a provider has sought reimbursement for supplies or services provided by a related organization.

Theoretically, in all the above cited cases, the federal government could have charged fraud. In the instant case, petitioner was deprived of his statutory right to challenge the intermediary's determination and his due process and equal protection rights were thereby violated.

There have also been cases in which a related organization situation has been held to exist, but the statutory exceptions to the rule have been applied. See, Blue Cross Association Provider Appeal Decision 52-76-1 CCH Medicare Medicaid Guide #27,812; *Northwest Community Hospital v. Califano*, 442 F. Supp. 949 (D.C. Col. 1977).

Under this situation and in the assumption that the government can file a criminal action for fraud upon the sole determination of the intermediary, it could happen that, no matter what the provider claims, a fraud action be charged. This, obviously, is not the intention of the Medicare Act. Thus, the Court of Appeals committed an error which will have national implications in respect to the administration of the Medicare program. In essence, petitioner submits that the doctrine of primary jurisdiction was misapplied in this case and petitioner's rights to due process of law and equal protection of the laws were violated.

## CONCLUSION

For the reasons stated, this petition for a writ of certiorari should be granted.

In San Juan, Puerto Rico, this 7th day of February, 1986.

/s/ Pedro J. Varela

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# APPENDIX

# United States Court of Appeals
# For the First Circuit

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No. 83-1713

UNITED STATES OF AMERICA,
*Appellee,*

v.

GUILLERMO A. ALEMANY RIVERA,
*Defendant, Appellant.*

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No. 83-1733

UNITED STATES OF AMERICA,
*Appellee,*

v.

EDGAR M. STELLA PEREZ,
*Defendant, Appellant.*

---

**APPEALS FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF PUERTO RICO**
[Hon. Juan M. Perez-Gimenez, *U.S. District Judge*]

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Before
Campbell, *Chief Judge*
Aldrich and Torruella, *Circuit Judges.*

---

*Pedro J. Varela* for appellant Guillermo A. Alemany Rivera.
*Harvey B. Nachman* with whom *Eduardo Morales-Coll* was on brief for appellant Edgar M. Stella Perez.
*John C. Carver,* Trial Attorney, Fraud Section, Criminal Division, U.S. Department of Justice, with whom *Daniel F. Lopez-Romo,* United States Attorney, was on brief for appellee.

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December 26, 1985

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CAMPBELL, *Chief Judge.* Defendants-appellants Dr. Edgar M. Stella-Perez and Guillermo A. Alemany-Rivera appeal from their convictions in the United States District Court for the District of Puerto Rico. We affirm.

I.

On July 7, 1982, defendants-appellants Stella and Alemany were jointly charged in a nine-count indictment. Count one charged Stella, the President, Chairman of the Board of Directors, and former Medical Director of the Hospital Nuestra Senora de la Guadalupe in Hato Rey, Puerto Rico (the "Hospital"), and Alemany, the former controller of the Hospital, with conspiracy to defraud the Departments of Housing and Urban Development ("HUD") and Health and Human Services ("HHS") in connection with a federally insured $12.46 million mortgage loan obtained by the Hospital for remodeling and expansion. Count one alleged that Stella and an unindicted co-conspirator named Jose A. Cardona-Alvarez, the Hospital's former assistant administrator, controlled a furniture company known as Casa Cardona, Inc., and its subsidiary, an equipment company by the name of AAA Hospital Supply, Inc. Stella and Cardona allegedly used these two corporations, with Alemany's assistance, to siphon off the Hospital's mortgage funds by selling equipment and furnishings to the Hospital at inflated prices, and by charging the Hospital for equipment that the corporations never furnished.

Counts two through four of the indictment charged Stella and Alemany with submitting and causing to be submitted false documents to HUD to procure mortgage funds. Counts five through seven charged the defendants with submitting and causing to be submitted false Medicare cost reports for the years 1977, 1978, and 1979. Counts eight and nine charged Stella and Alemany with making, aiding, and abetting false oaths in bankruptcy in connection with personal bankruptcy petitions filed by Stella and his wife in 1979.

After a 30-day jury trial, Stella was found guilty on all counts, sentenced to a 20-year term of imprisonment, and

placed on probation for another five years on condition that he make restitution of $686,349. Alemany was found guilty on counts one, five, and six of the indictment, sentenced to ten years in prison, and fined $10,000. This appeal followed.

II.

Stella and Alemany[1] were charged under counts five, six, and seven with submitting and causing to be submitted false Medicare cost reports on the Hospital's behalf for the years 1977, 1978, and 1979, in violation of 18 U.S.C. §§ 1001 & 1002 (1982).[2] It was alleged in these counts, *inter alia*, that the cost reports falsely represented to HHS's fiscal intermediaries, Blue Cross of Florida and Cooperativa de Seguros de Vida de Puerto Rico, that none of the costs for which the Hospital sought reimbursement "resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10," when in fact a number of expenses included in the cost reports arose out of transactions with AAA Hospital Supply.

---

[1] Stella was convicted on all three of these counts. Alemany was convicted only on counts five and six.

[2] Sections 1001 and 1002 provide:

> § 1001. *Statements or entries generally*
>
> Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned for not more than five years, or both.
>
> § 1002. *Possession of false papers to defraud United States*
>
> Whoever, knowingly and with intent to defraud the United States, or any agency thereof, possesses any false, altered, forged, or counterfeited writing or document for the purpose of enabling another to obtain from the United States, or from any other agency, officer or agent thereof, any sum of money, shall be fined not more than $10,000 or imprisoned not more than five years, or both.

The significance of whether the Hospital *had transacted* business with a related organization was that equipment acquired from such a source could only be reimbursed "at the cost to the related organization." 1 Medicare & Medicaid Guide (CCH) ¶ 5,679, at 1181 (1983). The Provider Reimbursement Manual contained the following definitions pertaining to related organizations:

> *Definitions.*—The term "related to the provider" means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies to the provider. . . . Common ownership arises when an individual, or individuals, holds significant ownership or equity in both the provider and the organization serving the provider. . . . The term "control" means that an individual or an organization has the power to influence or direct the actions or policies of both a provider and a related organization to a significant extent. . . .

*Id.*, ¶ 5,677, at 1879-3. These definitions substantially track the definitions of "related to the provider," "common ownership," and "control" contained in 42 C.F.R. § 405.427(b) (1984). At trial, the government introduced testimony explaining what related organizations were within the meaning of the Medicare Regulations.[3]

---

[3] For example, Mr. David Ramos-Usero, a former senior auditor in the San Juan Office of Blue Cross of Florida, testified on direct:

> Q: What is a related organization in Medicare terms?
>
> A: In Medicare terms, a related organization refers [to] when two or more parties with common ownership or control have business transactions.
>
> Q: All right, and why [does] Medicare[ ] care about that?

*(continued)*

Stella and Alemany argue that counts five, six, and seven of the indictment should have been dismissed, because there was never any finding by HHS or its intermediaries, Blue Cross of Florida and Cooperativa de Seguros de Vida de Puerto Rico, that AAA Hospital Supply was "related to" the Hospital as that term is defined in the Medicare Regulations and the Provider Reimbursement Manual.[4] Both defendants contend that, because the Medicare Regulations provide that, in the event of question, a determination of whether a provider has acquired supplies or services from a related organization is to be made in the first instance by an intermediary, and the provider then has a right of appeal to a Provider Reimbursement Review Board, *see* 42 C.F.R. §§ 405.1801-07, 405.1835 (1984), the district court was without jurisdiction to decide whether, contrary to the representations in the cost reports, the Hospital was "related to" AAA Hospital Supply.

We disagree. The district court's jurisdiction over counts five, six, and seven was predicated on allegations that the

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[3] continued

> A: Medicare would pay the cost only of the related party which would be the company making business with the hospital or the health institution, they would recognize only the cost and would not recognize any profit margin in those business transactions.
>
> Q. And why is that?
>
> A: Because [the] Medicare Program only accepts cost as a cost on the care of the Medicare beneficiaries.
>
> Q: Is there a particular disclosure requirement on the cost report, for related organizations?
>
> A: Yes, there is a work sheet on the cost report . . . which relate[s] to related organizations.

[4] Stella raised this issue below, but Alemany moved only to preclude the admissibility of the Provider Reimbursement Manual in evidence. To the extent that Alemany's argument involves an attack upon the subject matter jurisdiction of the district court, Alemany's failure to raise the issue below does not preclude his raising it on appeal. Fed. R. Crim. P. 12(b)(2); *Pon v. United States*, 168 F.2d 373 (1st Cir. 1948).

defendants had violated two criminal statutes, 18 U.S.C. §§ 1001 & 1002. *See* 18 U.S.C. § 3231 (1982). Patently, the district court's assumption of criminal jurisdiction over these counts did not usurp HHS's primary, civil jurisdiction over any claims made by the Hospital for reimbursement. *Compare, e.g., Kechijan v. Califano*, 621 F.2d 1 (1st Cir. 1980) (sustaining district court's refusal to exercise jurisdiction over physician's claims for reimbursement under the Medicare Act where physician had failed to first avail himself of administrative remedies).

Whether or not it was clear that AAA Hospital Supply was related to the Hospital would, of course, bear on whether or not the defendants had the requisite criminal intent. If the relationship was sufficiently questionable, the defendants could not be held criminally accountable for denying its existence. But there was overwhelming evidence in this case that the Hospital was "related to" AAA Hospital Supply within the meaning of the Medicare Regulations and the Provider Reimbursement Manual. For example, testimonial and documentary evidence introduced at trial tended to show that (1) Stella was the corporate president of both the Hospital and AAA; (2) Jose Cardona, the Hospital's assistant administrator with responsibility for equipment purchases, was also the sole employee of AAA; and (3) AAA had no stock and no capitalization, and its only source of income was the Hospital's mortgage fund. *See Burnham v. United States*, 297 F.2d 523, 524-25 (1st Cir. 1961); *cf. Nader v. Allegheny Airlines, Inc.*, 426 U.S. 290, 305-06 (1976) ("The standards to be applied in an action for fraudulent misrepresentation are well within the conventional competence of the courts, and the judgment of a technically expert body is not likely to be helpful in the application of these standards . . . .").

Alemany contends that the district court's assumption of jurisdiction over these counts prevented him from showing that Casa Cardona, AAA Hospital Supply, and the Hospital fell within the exception to the rules governing

related organizations. *See* 42 C.F.R. § 405.427(d) (1984).[5] Nothing would have prevented Alemany, however, from presenting this issue to the district court. There is no indication he did so. There is, moreover, little if anything to indicate that the exception was applicable. We find no error on this score.

Alemany asserts that our ruling will open a veritable Pandora's box, and result in criminal fraud prosecutions whenever an intermediary determines that a provider has sought reimbursement for supplies or services provided by a related organization. But as we have indicated, a good-faith claim for reimbursement, made without intent to defraud the government, would not support a conviction under 18 U.S.C. §§ 1001 & 1002. *See, e.g., United States v. Weatherspoon*, 581 F.2d 595, 601 (7th Cir. 1978) ("[T]he intent element of 18 U.S.C. § 1001 . . . precludes a conviction for an honest misinterpretation of a government form.").

---

[5] Section 405.427(d) provides:

> *Exception.* An exception is provided to [the related organization] principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, where the provider has not nominated a fiscal intermediary, the Health Care Financing Administration), that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and that the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies. In such cases, the charge by the supplier to the provider for such services, facilities, or supplies shall be allowable as cost.

## III.

Stella raises principally four additional arguments on appeal:

1. First, Stella contends, as he did in his motion for judgment notwithstanding the verdict below, that the conspiracy count of the indictment should have been dismissed because Jose A. Cardona-Alvarez, an unindicted co-conspirator and a chief witness for the prosecution, testified on cross-examination that the defendants neither intended nor agreed to defraud the government. Stella argues that, in the face of Cardona's denials, no rational finder of fact could have found him guilty of conspiracy beyond a reasonable doubt.

We disagree. As we recently observed in *United States v. Drougas,* 748 F.2d 8, 15 (1st Cir. 1984) (citations omitted),

> The gist of conspiracy is an agreement to disobey or to disregard the law. Two types of intent must be proven: intent to agree and intent to commit the substantive offense. . . . A conspiratorial agreement may be proven by circumstantial as well as direct evidence. . . . "A common purpose and plan may be inferred from a development and collocation of circumstances." . . . The government need not exclude every reasonable hypothesis inconsistent with guilt with respect to each piece of circumstantial evidence. Rather, "the question is merely whether the total evidence, including reasonable inferences, when put together is sufficient to warrant the jury to conclude that defendant is guilty beyond a reasonable doubt."

As *Drougas* makes clear, agreement and intent need not be proven by direct evidence; they may be inferred circumstantially. Furthermore, a conspiratorial agreement need not be express, but may consist of no more than a tacit understanding. *United States v. Pintar,* 630 F.2d 1270, 1275 (8th Cir. 1980).

Here, although Cardona denied on cross-examination that he intended or agreed with Stella to defraud the government, there was ample evidence from which the jury could infer the contrary. For example, Cardona testified on direct that he revived Casa Cardona in 1973 at Stella's behest, that AAA Hospital Supply was created to supply the Hospital with medical equipment, and that AAA invoiced the Hospital for equipment that it was unable to purchase because, at Stella's direction, monies that AAA received from the lending institution to pay for equipment were used for payments to both Stella and Stella's personal creditors. In short, the jury could have found that Stella's conclusions concerning his actions were squarely at odds with his actions themselves.

2. Next, Stella argues, as he did below, that his convictions under counts two, three, and four of the indictment should be reversed, because the government failed to prove the materiality of the false representations made in connection with these counts. Counts two, three, and four all alleged violations of 18 U.S.C. §§ 1001 & 1002 (1982).[6] As the Eleventh Circuit recently observed in *United States v. Lopez,* 728 F.2d 1359, 1362 (11th Cir.) (per curiam) (citations and footnotes omitted), *cert. denied,* 105 S.Ct. 112 (1984),

> The requirement [in 18 U.S.C. § 1001] that the falsification be of a "material" fact, while only contained in the first clause of the statute, has been read into the entire statute so as to exclude trivial falsifications from its coverage. . . . To be "material," a falsification "must have a natural tendency to influence, or be capable of affecting or influencing, a government function." . . . It makes no difference that a specific falsification did not exert influence so long as it had the *capacity* to do so.

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[6] *See* note 2, *supra.*

As *Lopez* makes clear, the government need not demonstrate that the falsification *actually* influenced a government function, but only that it *might have* influenced a government function. *See also United States v. Notarantonio*, 758 F.2d 777, 785–86 (1st Cir. 1985).

Counts two, three, and four of the indictment charged Stella[7] with submitting letters to the HUD office in Hato Rey, Puerto Rico seeking authorization for the release of mortgage escrow monies to pay for, respectively, a "Pho/sonic Ultrasound Scanner," a "Dynacamera 4/15," and a "Titanos 800MA X-ray Unit" which, contrary to Stella's representations, had not been purchased through AAA Hospital Supply. At trial, the government presented evidence tending to show that the Pho/sonic Ultrasound Scanner was neither purchased through AAA nor received by the Hospital. Instead, Stella attempted to lease an ultrasound scanner from a company in Philadelphia, and purchased such a device only after this attempt failed. Because the HHS engineer responsible for verifying the Hospital's equipment acquisitions for HUD did not find an ultrasound scanner on the premises at the time of his inspections, no escrow funds were ever disbursed for the purchase of the scanner. As to the Dynacamera 4/15 and the Titanos X-ray unit, the government's evidence tended to prove that, although the Hospital purchased both of these machines, they were not supplied by AAA as represented by Stella, but were supplied by other equipment companies who were not paid for this merchandise by the time the Hospital went into receivership in June of 1979.

With respect to all three of these counts, Stella argues that, because under the escrow deposit agreement only $447,000 was held by the Hospital's mortgagee, Merrill Lynch, Hubbard, Inc. for the purchase of hospital equipment, and the HHS engineer responsible for verifying equipment acquisitions for HUD accounted for over $600,000 worth of equipment on the premises, Stella's false representations were

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[7] Alemeny was also charged in this part of the indictment, but the jury acquitted him on all three of these counts.

immaterial because they did not result in the disbursement of any monies that would not have been disbursed anyway. However, the test for materiality under 18 U.S.C. § 1001 is not whether a false statement actually influenced a government function, but whether it had the capacity to influence a government function. *United States v. Notarantonio*, 758 F.2d at 785.

In the case at bar, Stella's falsifications were clearly capable of resulting in the fraudulent procurement of government funds. With respect to the Dynacamera 4/15 and the Titanos X-ray Unit, Stella's misrepresentations resulted in the disbursement of escrow monies not to the true vendors of the equipment, but to AAA Hospital Supply. Similarly, although HUD did not authorize the disbursement of escrow funds for the Pho/sonic Ultrasound Scanner, HUD plainly could have relied on Stella's misrepresentations to its detriment, because the HHS engineer might well have been tricked into believing that the Hospital had purchased an ultrasound scanner if Stella had been successful in leasing one.

3. Next, Stella contends that his conviction on counts eight and nine, the bankruptcy counts, should be reversed because the district court erred in denying his pretrial motion to sever these counts under Fed. R. Crim. P. 8(b). Rule 8(b) provides:

> *Joinder of Defendants.* Two or more defendants may be charged in the same indictment or information if they are alleged to have participated in the same act or transaction or in the same series of acts or transactions constituting an offense or offenses. Such defendants may be charged in one or more counts together or separately and all of the defendants need not be charged in each count.

Stella argues that the bankruptcy counts were improperly joined, because they were not part of "the same series of acts or transactions" that formed the basis for the remaining counts in the indictment.

In support of this contention, Stella relies in part on our analysis of Rule 8(b) in *United States v. Turkette*, 632 F.2d 896, 907-09 (1st Cir. 1980), *rev'd on other grounds*, 452 U.S. 576 (1981). However, in *Turkette* we observed that, while the term "series" in Rule 8(b) requires "something more than mere 'similar acts,' " the "[r]elatedness of offenses can be established by demonstrating that essentially the same facts must be shown for each of the consolidated crimes." 632 F.2d at 907-08.

Here, although counts eight and nine were not alleged as part of the conspiracy charged in count one of the indictment, they were interrelated with the substantive offenses charged in counts two through seven. For example, both counts eight and nine charged the defendants[8] with knowingly and fraudulently failing to disclose to the bankruptcy court that AAA Hospital Supply was one of the businesses operated by Stella during the three years previous to 1979. Plainly, the evidence necessary to prove that Stella operated AAA overlapped with the evidence necessary to prove the frauds alleged in the remaining counts of the indictment. *See United States v. O'Connell*, 703 F.2d 645, 648-49 (1st Cir. 1983) (joinder of offenses under Rule 8(b) proper where "facts necessary to show guilt on the stolen goods charges made up an important subset of those needed to show guilt on the perjury charge").

4. Last, Stella argues that there was insufficient evidence to sustain his conviction on counts five, six, and seven. As Stella did not raise this issue below, it is not properly before us here. *United States v. Cox*, 752 F.2d 741, 747 (1st Cir. 1985). In any event, we have reviewed the record and, taking all the inferences that may reasonably be drawn therefrom in the light most favorable to the government, *United States v. Quejada-Zurique*, 708 F.2d 857, 859 (1st Cir.), *cert. denied*, 464 U.S. 855 (1983), we are satisfied that the evidence was more than sufficient to support Stella's conviction on these counts.

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[8] Alemany was acquitted by the jury on both of these counts.

## IV.

Alemany also raises several additional arguments on appeal:

1. First, Alemany contends that the district court erred in denying his motions for dismissal of the indictment at the close of the government's case and, at the close of trial, for a judgment of acquittal notwithstanding the verdict, because there was insufficient evidence to support his conviction. Because the government concedes that its case against Alemany "is not an overwhelming one," we will review the evidence against Alemany in some detail.

Alemany was convicted on the conspiracy count of the indictment as well as on counts five and six, which alleged that the defendants had submitted and caused to be submitted false Medicare cost reports for 1977 and 1978. As to the conspiracy count, Alemany contends, *inter alia*, that contrary to the allegations contained in the indictment, the government failed to produce any evidence that he was involved in the concealment of the relationship between Casa Cardona, AAA Hospital Supply, and the Hospital, or that he derived any gains from the conspiracy.

We cannot agree. The government's evidence at trial tended to show that Alemany was employed as the Hospital's controller from May of 1976 to March of 1979, and that he was a skilled accountant familiar with the requirements of the Medicare Regulations. Mr. David Ramos-Usero, a former auditor for Blue Cross of Florida, testified that in July of 1978 he attended a meeting with Alemany and other representatives of the Hospital at which Ramos informed the Hospital representatives that he believed there was a related organization problem with respect to the Hospital's 1976 and 1977 cost reports. Mr. Ramos explained that the basis for Blue Cross's concern was that it appeared that Jose Cardona was working for Casa Cardona and AAA Hospital Supply as well as the Hospital, and was in a position to influence all three

of these corporations. In response, Alemany denied that the three corporations were related, because Stella was the only one who made decisions for the Hospital.

Sometime after this meeting, Ramos went to the Puerto Rico Department of State and obtained copies of two letters addressed to the Department which indicated that Stella was the corporate president of both Casa Cardona and AAA Hospital Supply. When Ramos telephoned Alemany and confronted him with this information, Alemany told Ramos that the letters were in error and would be corrected, but Ramos never heard from Alemany again on this subject.

Furthermore, although Alemany contends that there was no evidence that he profited in any way from the conspiracy, there was testimony that Stella permitted Alemany and one Dr. Edgardo Grovas-Rodriguez to operate a corporation known as the Hato Rey Medical Group out of the Hospital from July of 1977 until early 1979, and that a $190,000 debt owed by the Medical Group to the Hospital was written off the Hospital's books in 1979 while Alemany was working as the assistant to the Hospital's fiduciary in bankruptcy, James Stuckey. Thus, while there may have been no evidence that Alemany had a direct financial stake in the fraudulent diversion of mortgage funds through Casa Cardona and AAA Hospital Supply, there was evidence from which the jury could have inferred that Alemany profited in other ways by cooperating with Stella and furthering the aims of the conspiracy.[9]

In light of this evidence, and given Alemany's position of authority within the Hospital and his control of the Hospital's accounting department, the jury was not obliged to believe that he was an unwitting pawn in a covert conspiracy between Stella and Cardona. We said in *United States v. Marsh*, 747 F.2d 7, 13 (1st Cir. 1984), "if the government proves

[9] A defendant, of course, may be guilty of participation in a criminal conspiracy without actually profiting from or having any financial stake in it. *See, e.g., United States v. Noah*, 475 F.2d 688, 697 (9th Cir.), *cert. denied*, 414 U.S. 821 (1973).

beyond a reasonable doubt at least a slight, though willing and knowing, connection between a defendant and a conspiracy, an appellate court will affirm the defendant's participation in that conspiracy." Although the evidence implicating Alemany in the conspiracy was largely circumstantial, we are satisfied that, viewed in the light most favorable to the government, it was sufficient to have persuaded a rational jury of the fact that Alemany was guilty beyond a reasonable doubt. *See, e.g., United States v. Cincotta*, 689 F.2d 238, 240–41 (1st Cir.), *cert. denied*, 459 U.S. 991 (1982).

As to count five of the indictment, Alemany argues that there was insufficient evidence to convict him of falsifying the 1977 Medicare cost report, because the cost report was based on certified financial statements prepared not by him, but by an independent accounting firm which also prepared the financial statements for Casa Cardona and AAA Hospital Supply. Similarly, with respect to count six of the indictment, Alemany contends that he could not have played any part in falsifying the 1978 Medicare cost report, because he left his position as Hospital controller in March of 1979, the cost report was submitted by his successor in April, and Alemany did not return to work at the Hospital as an assistant to the fiduciary in bankruptcy until May of 1979.

We think there was sufficient evidence on both of these counts to support Alemany's conviction. Not only was Alemany listed as one of the preparers of the 1977 cost report, but he signed the transmittal letter that was sent with the report to Blue Cross of Florida. Although Alemany was not employed at the Hospital when the 1978 cost report was submitted to the Cooperativa de Seguros de Vida de Puerto Rico in April of 1979, Alemany's successor, Mr. Abel Lopez, testified that he frequently consulted with Alemany during this period on Hospital accounting matters. There was also evidence to suggest that the 1978 cost report was prepared from trial balances created during Alemany's tenure as controller. A conviction under 18 U.S.C. § 1001 can rest on evidence that the defendant knowingly and wilfully caused

a false statement to be made to a government agency; the defendant need not have prepared the statement himself. *United States v. Mouton*, 657 F.2d 736 (5th Cir. 1981). Furthermore, even if the evidence on count six was insufficient to support a violation of section 1001, the jury could have found that he was guilty of aiding and abetting such a violation under 18 U.S.C. § 1002. *See, e.g., United States v. Singh*, 628 F.2d 758, 765-66 (2d Cir.), *cert. denied*, 449 U.S. 1034 (1980).

2. Next, Alemany argues that the district court committed reversible error in denying his motion for severance of his trial from that of Stella under Fed. R. Crim. P. 14. A severance motion made pursuant to Rule 14 is a matter for the district court's discretion, and we will reverse the denial of such a motion only if the defendant is able to make a strong showing that the denial deprived him of a fair trial. *United States v. Bautista*, 731 F.2d 97, 99-100 (1st Cir. 1984); *United States v. Arruda*, 715 F.2d 671, 679 (1st Cir. 1983). Here, Alemany contends in conclusory fashion that he was unfairly prejudiced by the "spillover effect" of the government's case against Stella, and effectively found guilty by association. The district judge, however, expressly cautioned the jury that it was their duty "to give separate personal consideration to the case of each individual defendant." Alemany was acquitted on six of the nine counts with which he was charged. Thus, it would appear that the jury in fact gave individualized attention to his case. *United States v. Greenleaf*, 692 F.2d 182, 187 (1st Cir. 1982), *cert. denied*, 460 U.S. 1069 (1983); *United States v. Tashjian*, 660 F.2d 829, 834 (1st Cir.), *cert. denied*, 454 U.S. 1102 (1981).

3. Last, Alemany argues that his sentence of ten years in prison and a $10,000 fine, although within the statutory limits of the crimes for which he was convicted, cannot stand because the district judge imposed the sentence mechanistically, without giving individualized consideration to the mitigating factors in his case. The record of the proceedings at Alemany's sentencing hearing has been lost, but the government has filed a summary of these proceedings without objection from the defendant.

We have reviewed the government's summary, and are satisfied that there is no merit to Alemany's contentions. Not only did the district judge specifically advert to certain factors that he viewed as aggravating Alemany's conduct but, at the close of the proceedings, he informed the parties of aggravating factors in the presentence report that he had excluded from his deliberations, even though they had apparently not been objected to by the defendant. Alemany's sentence was within the bounds of the district court's discretion, and we see no defect in the manner in which it was imposed. We have no authority to change it. *See United States v. Pasarell*, 727 F.2d 13, 17–18 (1st Cir.), *cert. denied*, 105 S.Ct. 107 (1984).

*Affirmed.*